



**Consumers for
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Health Care
COALITION**

*Advocating the right to health care
for every man, woman and child.*

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September 5, 2008

VIA hand delivery and Electronic Mail

Mila Kofman, Superintendent
Attn.: Vanessa J. Leon, Docket No. INS-08-900
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IN RE: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for
the Fourth Assessment Year, Docket No. INS-08-900

Dear Superintendent Kofman:

Enclosed for filing in the above matter please find Consumers for Affordable Health Care's
Reply Brief.

Please contact me directly should you have any questions.

Sincerely,

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE)
MEASURABLE COST SAVINGS) REPLY BRIEF OF CONSUMERS FOR
DETERMINED BY DIRIGO) AFFORDABLE HEALTH CARE
HEALTH FOR THE FOURTH)
ASSESSMENT YEAR)
)
)
Docket No. INS-08-900)

FILING COVER SHEET

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NOW COMES intervenor, Consumers for Affordable Health Care (“CAHC”), by and through its legal counsel, and hereby files its Reply Brief in accordance with the Superintendent’s August 18, 2008 Order Setting Actual Hearing Date, Ruling on Interventions, and Establishing Procedures, sections I - IV.

INTRODUCTION

In our opening brief, Consumers for Affordable Health Care set out the standard of review and arguments in support of a finding by the Superintendent of Insurance that the evidence in the record reasonably supports the determination of each of the cost savings measured by the Dirigo Health Agency Board of Trustees.

CAHC represents ratepayers and consumers who are the ultimate payers of health care and health coverage costs in Maine. Any assessment resulting from the Savings Offset Payment process will be borne ultimately by the employees of employers that offer coverage and the ratepayers of insurance carriers. Unlike the self-described “payer intervenors,” CAHC uses this brief to respond to or elaborate on a limited set of relevant arguments made by those intervenors and the DHA. CAHC argues that there is evidence in the record that provides reasonable support to conclude that the Dirigo initiatives have resulted in aggregate measurable cost savings totaling at least \$149.6 million for the fourth assessment year.

ARGUMENT

In the interest of economy and reducing duplication, CAHC adopts the brief of Dirigo Health filed on September 2, 2008 in its entirety as its own.

I. Actual Dirigo Savings Likely Exceed the Measured Savings.

The Dirigo Health Agency’s report enumerates dozens of cost saving initiatives, AR 4-64 at pages 25-26 (Appendix B: Dirigo Health Reform Act Initiatives), only a fraction of which were subject to measurement in the proceeding below. For one cost saving initiative alone, CMAD, the

range of measured savings was from \$119.4 million to \$396.5 million. AR 4-64 at page 54 (Appendix G: CMAD Calculations). In short, it must be borne in mind that this proceeding is focused only on the measured savings of which the outside range exceeds the Boards determination by a factor of 2.65.

II. Recoverability Is Not An Issue

The self-described payer intervenors argue as they have in the past that aggregate savings means recoverable. However, the Superintendent rejected that argument from the very first proceeding and made clear that reductions in the overall cost of health care constitute recoverable savings. He stated:

However, there are also two mixed questions of fact and law which the Superintendent must consider in evaluating the reasonableness of the Dirigo Filing. First, some intervenors contend that the statutory reference to aggregate cost savings is a word of limitation, placing a restriction on the type of cost savings that may be considered by Dirigo and thus on the methodology that it may employ in evaluating the savings. *To the contrary, this adjective simply underscores the need to consider the totality of the cost savings available.* Whether a component-by-component-based methodology is appropriate or a more global methodology is necessary goes to the reasonableness of the specific measurement at issue and could be different for different types of measurements.

Second, some intervenors contend that cost savings refers to actual cost savings to payors, while Dirigo has evaluated cost savings to the health care system as a whole without regard to whether they have actually been passed through to payors in the form of reduced fees and charges. Because the evidence on the record does not allow a meaningful separation of realized and unrealized savings, it is necessary for the Superintendent to decide whether the Boards interpretation provides a reasonable measure of cost savings. The Superintendent concludes that it does. *Measurable reductions in the overall cost of health care constitute recoverable savings, and pursuant to 24-A M.R.S.A. 6913(7), it is the responsibility of payors and providers to negotiate in good faith to pass these savings through to consumers, regardless of whether or not they would do so in the absence of the Dirigo Act.*

Decision and Order, INS-05-700, IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE FIRST ASSESSMENT YEAR, Section V, Subsection A (web version) [Italics added].

In other words, it is up to payers to bargain with providers to recover the savings. It is not the responsibility of the Dirigo Health Agency to replace the negotiating functions of insurers and large employers in the free market. Payers' real concern may be found in Maine's highly consolidated health care market, in which they are unable or unwilling to bargain with large health providers for

lower prices, but that is not Dirigo's responsibility nor is it an issue before the Superintendent in this proceeding.

III. Using More Powerful Cost Savings Analyses Measured Savings More Accurately

While payer intervenors note that the determination of cost savings is higher this year than in the last three years, their complaints are rooted in the results of previous analyses, which did not apply a regression analysis to control for various variables, but rather simply trended data forward. The Superintendent determined that such trending of limited data would become less reliable over time and suggested the use of a multivariate regression analysis. Dr. Thorpe agreed.

MR. COLLERAN: Based on your experience is it appropriate to use the sort of multi-state multivariate regression analysis that schramm-raleigh used in this case?

MR. THORPE: Sure, I think it's fairly standard to pick a set of controls that would be outside of the State of Maine to ask the question what would have happened in the State of Maine in the absence of Dirigo. *So it's a more powerful way of doing the analysis than simply just relying on trending Maine State only data forward.*

AR 2-60 at p.24, lines 9 – 19.

A. The Unregressed Data Offered by Dr. Dobson Supports and Validates the Regressed CMAD Savings Determined by the Dirigo Board

Payer intervenors argue about the reliability of the U.S. model, but cannot dispute that the unregressed data offered by Dr. Dobson supports and validates the determination of Dirigo's Trustees and the conclusion of DHA experts.

MR. COLLERAN: Is there anything in there that similarly shows this empirical data that there are savings in Maine due to cost reductions?

MR. SCHRAMM: Actually there is. If you look at Table 1 in Dr. Dobson's pre-filed testimony, he has a summary of what has gone on. This is actually pulled right out of Dr. Dobson's pre-filed testimony. This table shows a comparison of the average compound rates of growth, and what Dr. Dobson did was he looked at the pre-Dirigo period which I talked about, 2000 to 2003 and he looked at the post-Dirigo period and the way this table works is if you just walk across, you take the 5.3, subtract the 3.5 and you get 1.8. So what that says is for all states the change was about 1.8. **Look at Maine only. It goes from 7.8 to 4.3. That's a 3.5 percentage drop.** Maine itself has had a substantially greater drop than all other states, and, again, this is Dr. Dobson's summary and what it shows is – **the simple data without any statistical analysis on it shows that there's been a substantial drop in trend in Maine greater than that which was experienced on a national level.**

AR 2-60 at p. 34, lines 4-25 and p. 35, lines 1-4 (Bold added).

Dr. Thorpe supported Mr. Schramm's observation. "The actual data are telling me here that the growth in Maine has come down dramatically post-Dirigo relative to the U.S. trends." AR 2-60 at 92, lines 8-11.

B. The Savings Are Attributable to Dirigo

Dr. Thorpe testified that the CMAD and bad debt and charity care savings are attributable to Dirigo.

MR. DITRE: [...] I just have one question for Dr. Thorpe, and it is in regards to the intervenors – each of the intervenor's experts as well as their briefs made a point to say that these are simply comparing periods of time and that the effects that we are seeing, the savings that we're seeing are not related to Dirigo. In your expert opinion, looking at the results of the regression analysis, is it your opinion that the results – the savings results here are attributable to the hospital savings initiative under the Dirigo Health Program?

DR. THORPE: Yes, and, in addition, for the additional anecdotal information that Mr. Schramm brought forth about what the hospitals and the health plans are saying about it, let me just say in terms of the statistics, they went to great pains to make sure that we accounted for national trends during the Dirigo time period, for things unique to Maine that are different about this state and in the interactions of all of these things, and the two things – the two take aways you have is, one, the cost trajectory is substantially down in the post-Dirigo period, so the standard of statistical analysis is to do it this way, and there is no other way statistically to isolate the Dirigo effect other than the way that they've done it which is through these indicator variables and very careful controlling for what's going on in the United States outside of Maine, what's going on inside the State of Maine that's not related to this time period as well. The only thing that you have to ask yourself is that on the dramatic reduction in cost, and as we're going to talk about later on, the dramatic reduction in the number of uninsured 2005 – 2006. **What else happened dramatically big in this state that would have such a strong reduction in the underlying cost structure, that was not related to your big initiative which is Dirigo? So that's sort of the compelling piece of this. There is no competing big public policy intervention that has happened in 2005 and 2006 that statewide would have driven cost down in the way that we see in the actual data and in these statistical adjustments. So I think it's a completely reasonable estimate.** It is the standard that we use in doing program estimates which is providing this indicator variables but very carefully controlling for trends nationally and trends within the state. In the absence of any other competing explanation that's major, and it would have to be a major intervention that is unique to Maine, that's not happening anyplace other than Maine, I think the answer is I'm very comfortable with this as our best estimate of what impact Dirigo has had on CMAD and later on we'll talk about bad debt and charity care.

AR 2-60 at p. 93, lines 22-25, p. 94, lines 1 – 25, p. 95, lines 1 – 25, and p.96, lines 1 – 5.

Dr. Dobson agreed. While identifying other states where there were reductions in cost growth, when asked if the reductions in Maine beyond the national trends (i.e., the difference between the 1.8 percent drop nationally and the 3.5 drop in Maine alone) could be attributable to Dirigo, he said “Yes.”

MR. DITRE: [...] Now, following the logic of the statement that you just made about the other states, isn't it possible that the other portion of the reduction in the state of Maine is due to the rate reforms adopted by the Dirigo Health act?

DR. DOBSON: Yes, that's – that was my question mark on my graph, that's exactly right.

AR 3-61 at p. 78, lines 15-21.

C. The Savings Are Larger This Year In Part Because Previous Year's Savings Continue in the System

In addition to the use of a more powerful and accurate method of measuring savings, the interchange between Trustee Beal and Dr. Dobson underscores in part why the savings this year are larger than previous years.

MR. BEAL: I have a question about the Chamber 14 illustration. Let's assume that as you hypothesize in year one, there was a savings. Let's say it was a million dollars. And then let's assume the slope of increase in CMAD for the rest of the country and Maine were identical.

DR. DOBSON: Yes.

MR. BEAL: That million dollar savings would have been achieved in year one correct?

DR. DOBSON: Yes.

MR. BEAL: And it also would have been in the system year two, correct?

DR. DOBSON: Yes.

MR. BEAL: And in year three?

DR. DOBSON: Yes.

MR. BEAL: So the savings are still in the system and being enjoyed by the system, correct?

DR. DOBSON: Yes.

AR 3-61 at pp. 96, lines 14 – 25 and p. 97, lines 1 – 6.

IV. Fifty-five Percent (55%) Confidence Level Using the Universe of CMAD Data Is Incredibly Important

It is important to remember what a “level of significance” indicates statistically and why it is so important here given the null hypothesis posed by DHA’s experts.

What does the level of significance tell us? According to Murray R. Spiegel, PhD, in mathematics from Cornell University, who authored the one of standard treatises used by mathematicians called “Statistics, Schaum’s Easy Outlines, Based on Schaum’s Outline of Theory and Problems of Statistics,” McGraw-Hill, 2000:

In testing a given hypothesis, the maximum probability with which we would be willing to risk a Type I error is called the level of significance, or significance level, of the test. This probability, often denoted by α , is generally specified before any samples are drawn so that the results obtained will not influence our choice. In practice, a significance level of 0.05 or 0.01 is customary although other values are used. If, for example, the 0.05 (or 5%) significance level is chosen in designing a decision rule, then there are about 5 chances in 100 that we would reject the hypothesis when it should be accepted; that is, we are about 95% *confident* that we have made the right decision. In such case, we say that the hypothesis has been rejected at the 0.05 significance level, which means that the hypothesis has a 0.05 probability of being wrong.

Id. at p. 55 (Italics in original).

As DHA’s counsel noted in his brief, the p-value at 0.45 results in a 55% chance that the null hypothesis here is correct. Mr. Schramm testified that srHS’ hypothesis was that “[D]irigo has a negative impact on cost per CMAD[...].” AR 1-16 at p. 18, line 416.

The fact that we can be 55% confident that the null hypothesis that Dirigo caused the savings is correct is important for two reasons. Again, going to the reasoning behind the statistics.

If we reject a hypothesis when it should be accepted, we say that a *Type I error* has been made. If on the other hand, we accept a hypothesis when it should be rejected, we say that a *Type II error* has been made. In either case, a wrong decision or error in judgment has occurred. In order for decision rules (or tests of hypotheses) to be good, they must be designed so as to minimize errors of decision. This is not a simple matter, because for any given sample size, an attempt to decrease one type of error is generally accompanied by an increase in the other type of error. In practice, one type of error may be more serious than the other, and so a compromise should be reached in favor of limiting the more serious error. The only way to reduce both types of error is to increase the sample size, which may or may not be possible.

Id. at 54 (*Italics in original; underline added*).

Again, this is important because the U.S. model data was not a sample, it was the entire universe of data. Therefore, DHA's experts could not have "increase[d] the sample size." Using the entire universe of data and achieving a 55% chance that the null hypothesis is correct (Dirigo caused the savings) is critical. If there is any doubt that Dirigo caused the savings here, one only needs to ask the question Dr. Thorpe posed "**What else happened dramatically big in this state that would have such a strong reduction in the underlying cost structure, that was not related to your big initiative which is Dirigo?**" Of course, the answer is "nothing" and the failure of the payer intervenors to produce their own regression analysis to answer that question leaves the Superintendent with reasonable support in the evidence in the record for the Board's determination.

CONCLUSION

For the fourth assessment year, the various Dirigo initiatives have resulted in aggregate measurable cost savings of at least \$149.6 million. This figure is reasonably supported by evidence in the record and should be affirmed by the Superintendent.

Dated: September 5, 2008

Respectfully submitted,

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